Anthem Blue Cross Traditional HMO

Coverage Period: 01/01/2014 – 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs**Coverage for:Individual + Spouse, Family Plan Type:**HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/ca/calpers/hmo or by calling 1-855-839-4524.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$** 0.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services. See the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $1,500 per *member* $3,000 per family	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services with participating providers. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, any copay for testing and diagnosis of infertility, and health care that is not covered.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for
Does this plan use a network of providers?	Yes. *Anthem Blue Cross Traditional HMO.* Visit www.anthem.com/ca/calpers/hmo or call 1-855-839-4524 for a list.	You will choose a primary care doctor who is part of an Anthem Blue Cross Traditional HMO contracting *medical group*.
Do I need a referral to see a specialist?	Yes, unless the specialist is in the "Direct Access" or "Speedy Referral." Programs.	Not all medical groups take part in the Ready Access or Speedy Referral program. See our online directory of Anthem Blue Cross Traditional HMO providers for those that do.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services.**

Questions: Call 1-855-839-4524or visit us at www.anthem.com/ca/calpers/hmo
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www. anthem.com/ca/calpers/hmo or call 1-855-839-4524 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use _____ **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	100% Out of Pocket	————none————
	Specialist visit	$15 / visit	100% Out of Pocket	————none————
	Other practitioner office visit	$15 / visit	100% Out of Pocket	————none————
	Preventive care/screening/immunization	No Charge	100% Out of Pocket	————none————
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	100% Out of Pocket	————none————
	Imaging (CT/PET scans, MRIs)	No Charge	100% Out of Pocket	————none————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com/calpers	Generic drugs	$5 30 day supply $10 90 day supply	100% Out of pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies allowed at CVS Stores and CVS Caremark Mail Order.
	Preferred brand drugs	$20 30 day supply $40 90 day supply	100% Out of pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies allowed at CVS Stores and CVS Caremark Mail Order
	Non-preferred brand drugs	$50 30 day supply $100 90 day supply	100% Out of pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies allowed at CVS Stores and CVS Caremark Mail Order
	Specialty drugs	Specialty follows the tier structure above	100% Out of pocket	Specialty medication must be dispensed through CVS Caremark Specialty Pharmacy. All orders are dispensed 30 day supplies except RA/MS medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	100% Out of pocket	————————none————————
	Physician/surgeon fees	No Charge	100% Out of pocket	————————none————————
If you need immediate medical attention	Emergency room services	$50	100% Out of pocket	You do not have to pay the **$50** if you are admitted as an inpatient
	Emergency medical transportation	No Charge	100% Out of pocket	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Urgent care	$15 /visit	$15 /visit	You do not have to pay the **$15** if you are admitted as an inpatient
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	100% Out of pocket	————————none————————
	Physician/surgeon fee	No Charge	100% Out of pocket	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 /visit	100% Out of pocket	————————none————————
	Mental/Behavioral health inpatient services	No Charge	100% Out of pocket	————————none————————
	Substance use disorder outpatient services	$15 /visit	100% Out of pocket	————————none————————
	Substance use disorder inpatient services	No Charge	100% Out of pocket	————————none————————
If you are pregnant	Prenatal and postnatal care	No Charge	100% Out of pocket	————————none————————
	Delivery and all inpatient services	No Charge	100% Out of pocket	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	100% Out of pocket	$15 / visit for Physical therapy, occupational therapy, speech therapy, or respiratory therapy
	Rehabilitation services	$15 / visit	100% Out of pocket	Copay applies to visits for rehabilitation, such as physical therapy, chiropractic services, occupational therapy or speech therapy
	Habilitation services	$15 / visit	No Charge	Copay applies to visits for rehabilitation, such as physical therapy, chiropractic services, occupational therapy or speech therapy
	Skilled nursing care	No Charge	100% Out of pocket	Coverage is limited to 100 days/calendar year.
	Durable medical equipment	No Charge	100% Out of pocket	————————none————————
	Hospice service	No Charge	100% Out of pocket	————————none————————
If your child needs dental or eye care	Eye exam	No Charge	100% Out of pocket	————————none————————
	Glasses	Not Covered	Not Covered	Eyeglasses are not covered, except when needed after a covered and *medically necessary* surgery.
	Dental check-up	Not Covered	Not Covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Non-emergency care when traveling outside the US
- Weight Loss Programs
- Infertility Treatment
- Long-Term Care
- Over-the-counter Medications
- Private Duty Nursing
- Routine Foot Care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Hearing Aids
- Routine Eye Exam (Adult)
- Chiropractic Care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-839-4524. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Anthem Blue Cross CalPERS Customer Service at 1-855-839-4524 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care at (888) 466-2219 or www.dmhc.ca.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

[Insert heading and applicable tagline(s):

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-839-4524

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-839-4524

[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-855-839-4524

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,450
- **Patient pays** $ 90

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$
Copays	$
Coinsurance	$
Limits or exclusions	$90
Total	**$90**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $ 4,990
- **Patient pays** $ 410

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$
Copays	$410
Coinsurance	$
Limits or exclusions	$
Total	**$410**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.